Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Meeting
Monday, 24 November 2025 – Wednesday 26 November 2025

Virtual Meeting

Name of Registrant:	**Ernestina Memuna Diato**
NMC PIN:	02F1050O
Part(s) of the register:	Nurses part of the register Sub part 1 RN1: Adult nurse, level 1 (27 June 2002)
Relevant Location:	Leeds
Type of case:	Misconduct
Panel members:	Allison Brindley (Chair, Registrant member) Raj Chauhan (Lay member) Tracy Jones (Lay member)
Legal Assessor:	Michael Levy
Hearings Coordinator:	Monowara Begum
Facts proved:	Charges 1a, 1b, 2b and 2d
Facts not proved:	Charges 2a, 2c and 2e
Fitness to practise:	Impaired
Sanction:	**Suspension order (12 months)**
Interim order:	**Interim suspension order (18 months)**

Decision and reasons on service of Notice of Meeting

The panel was informed at the start of this meeting that the Notice of Meeting had been sent to Ms Diato's registered email address by secure email on 15 October 2025.

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Meeting provided details of the allegation, the time, dates and the fact that this meeting was heard virtually.

In light of all of the information available, the panel was satisfied that Ms Diato has been served with notice of this meeting in accordance with the requirements of Rules 11A and 34 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Details of charge

That you, a registered nurse:

1. On or around 30 August 2020, in relation to Patient A:
   a) Failed to conduct and/or record an assessment of their pain,
   b) Failed to record the admission of medication to them, namely Codeine Phosphate.

2. On or around 2 September 2020, you
   a) Failed to use the appropriate equipment to prepare liquid medication,
   b) Failed to use the appropriate measuring techniques to prepare liquid medication,
   c) Administered medication, namely Digoxin, to an unknown patient without checking their heart rate,
   d) Failed to appropriately dispose of medication, namely Bisoprolol that had fallen on the floor,
   e) Failed to administer time critical medication, namely Madopar and/or Co-Levodopa, in accordance with Patient A's medication plan.

AND in light of the above, your fitness to practise is impaired by reason of your misconduct.

Background

On 12 March 2021, the Nursing and Midwifery Council (NMC) received a referral from Ms Diato's employer, British United Provident Association Limited (BUPA). At the time of the allegations, Ms Diato was working as a nurse for BUPA, at [PRIVATE] (the Home).

On 30 August 2020, Ms Diato was working a day shift at the Home and was allocated a number of patients including Patient A. Patient A suffered from neck pain and was prescribed Paracetamol four times a day, Fenbid Gel three times a day and Codeine Phosphate up to four times a day, when required.

According to Patient A's Medication Administration Record (MAR) chart, Ms Diato had signed for Codeine Phosphate on two occasions on 30 August 2020, but did not:

- Record the time when Patient A was given the Codeine Phosphate in the MAR chart.
- Record that she had given Patient A Codeine Phosphate within Patient A's medication notes. These notes should include the date, time, medication given, the reason for giving the medication and the result of the medication.
- Record within the daily notes the care she had given to Patient A, what actions she took and if these were affective or not.
- Complete a pain chart for Patient A in order to assess their pain management.

On 2 September 2020, the new Clinical Lead (Witness 2), a registered nurse, worked alongside Ms Diato at the Home. During a medication round, a number of concerns were raised by the Clinical Lead in relation to medication management. The Clinical Lead explained witnessing Ms Diato pouring the wrong volume of liquid medication (20mls instead of the prescribed 5mls) into a cup to be administered. Further, Ms Diato then went onto use a syringe which she stated lacked any measurements to measure 5ml prescribed dose.

The Clinical Lead also raised concern that she had witnessed Ms Diato drop a tablet, Bisoprolol, onto the floor and then proceeded to pick this up to administer it to a patient, rather than dispose of this in line with the Medicines Management Policy.

The Clinical Lead raised concern that Ms Diato was about to administer medication, Digoxin, without first checking the patient's MAR chart or the patient's heart rate. No harm was caused as the Clinical Lead had stepped in and stopped Ms Diato.

During the same shift, the Clinical Lead allegedly witnessed a second near-miss with a patient. She stated that she saw Ms Diato about to give time critical medication for Parkinson's Disease, earlier than its due time.

Decision and reasons on facts

In reaching its decisions on the facts, the panel took into account all the documentary evidence in this case together with the representations made by the NMC.

The panel was aware that the burden of proof rests on the NMC, and that the standard of proof is the civil standard, namely the balance of probabilities. This means that a fact will be proved if a panel is satisfied that it is more likely than not that the incident occurred as alleged.

The panel had regard to the written statements of the following witnesses on behalf of the NMC:

- Witness 1: Deputy Manager and Senior Carer at the Home from 2012, and then Home Manager from September 2020, at the time of the incidents

- Witness 2: Unit Manager (Clinical Lead and Registered Nurse) at the Home from August 2020 until August 2021, at the time of the incidents

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor. It considered the documentary evidence provided by the NMC.

The panel then considered each of the disputed charges and made the following findings.

Charge 1a)

"That you a registered nurse:

1. On or around 30 August 2020, in relation to Patient A:
   a) Failed to conduct and/or record an assessment of their pain,"

This charge is found proved.

In reaching this decision, the panel took into account the Meeting Minutes between Witness 1 and Ms Diato that took place on 2 September 2020 and BUPA's Care Planning Policy Handbook, which states the following:

> *'The Pain and Medication plan is used to identify specific requirements related to medication administration, such as, self-administration or covert medication and whether the resident experiences pain.*
>
> *Remember when completing this plan:*
>
> *• 'Pain is what the person says it is' (McCaffrey, 1968). Pain is an individual sensation and the person's description of feeling pain or lack of pain should always be acknowledged, recorded and addressed.'*

The panel noted that in the Meeting Minutes, when Ms Diato was asked about how she knew how bad the pain was in relation to pain assessment, she had responded, *'I just observed'*.

The panel further noted that in the Meeting Minutes Witness 1 stated:

'…we have nothing because you haven't documented any of the events that happened and there's no documentation on the back of the MAR of when you gave pain relief'

Ms Diato, responded:

'Yes, that is my error. My paperwork has let me down and I know that's wrong'

Ms Diato had signed the notes of this meeting to indicate that she agreed. The panel concluded that, although Ms Diato stated that she carried out the pain assessment through observation, it noted that she did not use the recognised '*Abbey'* pain assessment tool. It further concluded that Ms Diato has admitted to not recording the assessment of pain of Patient A, in line with the Care Planning Policy handbook.

Accordingly, the panel finds charge 1a proved.

Charge 1b)

"That you a registered nurse:

1. On or around 30 August 2020, in relation to Patient A:
   b) Failed to record the admission of medication to them, namely Codeine Phosphate.

This charge is found proved.

In reaching this decision, the panel took into account Patient A's MAR chart, the Trained Staff or Carers Medication Notes, the Meeting Minutes between Witness 1 and Ms Diato that took place on 2 September 2020 and the Medicines Management Policy.

The panel noted that there is no time of medication administered recorded on the MAR chart although Ms Diato stated in the Meeting Minutes that she had administered Codeine

Phosphate at 14:00. It further noted that, in the Meeting Minutes, Ms Diato stated that she had a list of timings she had recorded that she administered the medication to Patient A, however she had not recorded it on the MAR chart, as she goes onto state:

> *'Yes, that is my error. My paperwork has let me down and I know that's wrong'.*

The panel determined that it was not clear that the Trained Staff or Carers Medication Notes belonged to Patient A, however, due to the references made to the chart in the Meeting Minutes whereby Witness 1 stated:

> *'…we have nothing because you haven't documented any of the events that happened and there's no documentation on the back of the MAR of when you gave pain relief'*

The panel was of the view that this chart was the back of the MAR chart being referred to in the Meeting Minutes. The panel were further satisfied that this chart was the back of the MAR chart as there is cross-reference made in the witness statement of Witness 1, in which she stated that Codeine Phosphate was given at 20:40, which is also the time recorded on that chart.

Having regard to all the above, the panel was satisfied that the admission of medication was not recorded in line with the Medicines Management Policy which states:

> '*Whenever staff administer a PRN medication they are required to:*
> • *Sign the MAR*
> • *Document in the Daily Notes that the PRN medication was given*
> • *State what the clinical indication for its use was e.g. constipation/pain etc.*
> • *State what outcome was achieved'*

Accordingly, the panel finds charge 1b proved.

Charge 2a)

“That you a registered nurse:

2. On or around 2 September 2020, you
    a) Failed to use the appropriate equipment to prepare liquid medication,”

This charge is found NOT proved.

In reaching this decision, the panel took into account the Medicine Management Policy and the Meeting Minutes between Witness 1 and Ms Diato that took place on 2 September 2020. It noted that there is nothing specific in the Medicine Management Policy to say what equipment to use when preparing liquid medication.

The panel noted that, Ms Diato, in the Meeting Minutes, had stated that she had a problem with her eyes and therefore had used a medication cup to pour the medicine into and then used a syringe to draw it out. The panel was of the view that the medication cup and the syringe are both appropriate methods to use.

The panel noted that the suggestion that the syringe used had no measurement on it, is only mentioned in the witness statements of Witness 2, and there was no other evidence to corroborate this.

The panel determined that on the balance of probabilities it was more likely than not that Ms Diato had used the appropriate equipment to prepare the liquid medication.

Accordingly, the panel finds charge 2a not proved.

Charge 2b)

“That you a registered nurse:

2. On or around 2 September 2020, you

b) Failed to use the appropriate measuring techniques to prepare liquid medication,

This charge is found proved.

In reaching this decision, the panel took into account the Medicines Management Policy, the witness statement of Witness 2 and the Meeting Minutes between Witness 1 and Ms Diato that took place on 2 September 2020.

The panel noted that there is nothing specific in the Medicines Management Policy on the appropriate measuring techniques to use when preparing liquid medication.

However, the panel noted that Witness 2 in her statement stated:

> *'…I watched Ms Diato pour out the liquid medication into a plastic medication pot. She held the pot up in the air to pour it out. She had poured 20 millilitres out instead of five millilitres…she was holding the pot up to the light and it was tilted…*
>
> *…Ms Diato then used a syringe to draw up the dose, However the syringe that she used had been used multiple times and had no measures left written on it…'*

The panel further noted that in the Meeting Minutes Ms Diato stated:

> *'…Yes, I have a problem with my eyes. I would pour into the medication cup then syringe it out of the cup*
>
> *…*
>
> *…There's not a lot of the medication left in the cup, I would wash it away'*

The panel determined that, on the balance of probabilities it is more likely than not that Ms Diato did not use the appropriate measuring technique when pouring out liquid medication. The medicine could have been drawn up directly into a syringe if the millilitre markings on

the cup were difficult to see. This would have enabled Ms Diato to both ensure the correct amount of medicine was administered and reduced wastage. Therefore, the panel finds charge 2b proved.

Charge 2c)

2. On or around 2 September 2020, you
   c) Administered medication, namely Digoxin, to an unknown patient without checking their heart rate,"

This charge is found NOT proved.

In reaching this decision, the panel took into account the witness statement of Witness 2, in which she indicated that she had intervened and did not let Ms Diato administer the medication, namely, Digoxin.

The panel concluded that Ms Diato did not administer any medication, and it was recorded as a near-miss.

Accordingly, the panel finds charge 2c not proved.

Charge 2d)

"That you a registered nurse:

2. On or around 2 September 2020, you
   d) Failed to appropriately dispose of medication, namely Bisoprolol that had fallen on the floor,"

This charge is found proved.

In reaching this decision, the panel took into account the Meeting Minutes between Witness 1 and Ms Diato that took place on 2 September 2020 and the Disposal of Medicines Policy in which it states:

'The service has a duty of care to ensure that all waste is disposed of safely. This includes disposing of medicines safely.

Medicines (prescribed or homely remedies) that are no longer required including the following circumstances:

• Refused and dropped/damaged doses of medication'

The panel noted that Ms Diato had made admissions during the Meeting Minutes:

'…Did you know that it was wrong to give medication that has been on the floor?

…Yes, that was wrong'

The panel noted the contemporaneous evidence, in particular the statements of Witness 2, in which she stated that she witnessed Ms Diato drop a Bisoprolol tablet on the floor and when she had asked her what she was going to do with it, she had stated that she would give it to the patient as it was low in stock.

For the reasons above, the panel concluded that Ms Diato failed to dispose of medication in line with the Medicines Management Policy.

Accordingly, the panel finds charge 2d proved.

Charge 2e)

"That you a registered nurse:

2. On or around 2 September 2020, you
   d) Failed to administer time critical medication, namely Madopar and/or Co-Levodopa, in accordance with Patient A's medication plan."

This charge is found NOT proved.

In reaching this decision, the panel took into account the witness statement of Witness 2 and the Meeting Minutes between Witness 1 and Ms Diato that took place on 2 September 2020.

The panel noted that Witness 2 in her witness statement stated that Ms Diato was going to administer time critical medication at 09:10, however, Ms Diato in the Meeting Minutes stated that she was going to administer it around 09:35. This was not challenged by Witness 1 at the meeting.

The panel noted that at the time of the concerns raised, Witness 2 had thought that time critical medication had to be given within five minutes of the prescribed time, however in her witness statement she stated that she was mistaken and accepted the guidance said no more than 30 minutes of the prescribed time.

The panel further noted that Ms Diato in the Meeting Minutes stated:

> *'…I was doing my meds and I hadn't got to Pnt A. I was just popping the medication'*

The panel noted that there is a discrepancy regarding what the time frame was in which the medicine was dispensed. It noted that Ms Diato had only '*popped'* the medication in preparation for the medication rounds. It concluded that there is insufficient evidence to say what time Ms Diato administered the medication, and on the balance of probabilities it is more likely than not that she did administer the medication in the required time frame.

Accordingly, the panel finds charge 2e not proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether Ms Diato's fitness to practise is currently impaired. There is no statutory definition of fitness to

practise. However, the NMC has defined fitness to practise as a registrant's ability to practise kindly, safely and professionally.

The panel, in reaching its decision, has recognised its statutory duty to protect the public and maintain public confidence in the profession. Further, it bore in mind that there is no burden or standard of proof at this stage, and it has therefore exercised its own professional judgement.

The panel adopted a two-stage process in its consideration. First, the panel must determine whether the facts found proved amount to misconduct. Secondly, only if the facts found proved amount to misconduct, the panel must decide whether, in all the circumstances, Ms Diato's fitness to practise is currently impaired as a result of that misconduct.

Representations on misconduct and impairment

In coming to its decision, the panel had regard to the case of *Roylance v GMC (No. 2)* [2000] 1 AC 311 which defines misconduct as a 'word of general effect, involving some act or omission which falls short of what would be proper in the circumstances.'

The NMC invited the panel to take the view that the facts found proved amount to misconduct. The panel had regard to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives 2015' ("the Code") in making its decision.

The NMC identified the specific, relevant standards where Ms Diato's actions amounted to misconduct. The NMC submitted that Ms Diato's actions did fall significantly short of the standards expected of a registered nurse and amounted to breaches of the Code, in particular, 1.2, 10.1, 10.2, 10.3, 10.4, 13.1, 18.1, 18.2, 19.1, 19.4 and 20.1. The NMC submitted that the areas of concerns identified relate to basic nursing skills and practice. It submitted that Ms Diato's failings were significant departures from the fundamental principles of the Code. It further submitted that the misconduct in this case is serious because Ms Diato failed to provide safe and effective care to patients in her care.

The NMC referred the panel to case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin). The NMC submitted that limbs a), b) and c) of the *Grant* test can be answered in the affirmative in this case.

The NMC submitted that Ms Diato placed Patient A at risk of unwarranted harm when she failed to record the medication given to him, therefore placing Patient A at risk of having more medication administered to him. The potential for unwarranted harm was further exacerbated by Ms Diato's failing to conduct and/or record an assessment of Patient A's pain, therefore staff were prevented in being able to assess if his pain management was effective and if not, request a General Practitioner (GP) review.

The NMC submitted that Ms Diato's conduct has put patients at unwarranted risk of harm in the past and due to her lack of insight and remediation, there is a risk of the conduct being repeated, thus putting patients at risk of unwarranted harm in the future.

The NMC submitted that Ms Diato's conduct in this case undermines the trust the public places on nurses to practise kindly, safely and professionally, and has therefore brought the nursing profession into disrepute. It submitted that Ms Diato failed in the fundamentals of nursing practice by making serious medication omissions and errors.

The NMC submitted that Ms Diato's conduct in both failing to record the administration of medication and her failure in relation to safe administration of medication has breached the fundamental tenets of the profession.

The NMC referred the panel to the case of *R (on application of Cohen) v General Medical Council* [2008] EWHC 581 (Admin). It submitted that there is no evidence of insight or remediation on Ms Diato's part. The NMC told the panel that Ms Diato was initially granted undertakings by the Case Examiners (CE), however, Ms Diato disengaged with the process. Ms Diato had emailed the case officer on 26 March 2023 to say that she was not currently in living in the United Kingdom, that she had not been well and had been in Ghana for family support.

The NMC submitted that there is a continuing risk to the public due to Ms Diato's lack of insight and having not had the opportunity to demonstrate strengthened practice through work in a relevant area.

The NMC requires the panel to bear in mind its overarching objective to protect the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. The panel has referred to the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant* [2011] EWHC 927 (Admin).

The NMC submitted that there is a significant risk of harm if Ms Diato were allowed to practise unrestricted, and therefore a finding of impairment is required for the protection of the public.

The NMC submitted that there is a public interest in a finding of impairment being made in this case, to declare and uphold proper standards of conduct and behaviour. It submitted that the public would be appalled to hear of a nurse failing in basic nursing practices such as medication management and administration, poor record-keeping and failure to undertake patient observations. It further submitted that such conduct severely damages and undermines public confidence in the nursing profession and the NMC as the regulator.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 311, *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), and *General Medical Council v Meadow* [2007] QB 462 (Admin).

Decision and reasons on misconduct

When determining whether the facts found proved amount to misconduct, the panel had regard to the terms of the Code.

The panel was of the view that Ms Diato's actions did fall significantly short of the standards expected of a registered nurse, and that Ms Diato's actions amounted to a breach of the Code. Specifically:

*‘**1 Treat people as individuals and uphold their dignity***
To achieve this, you must:

1.2 make sure you deliver the fundamentals of care effectively

6 Always practise in line with the best available evidence
To achieve this, you must:

…

6.2 maintain the knowledge and skills you need for safe and effective practice

10 Keep clear and accurate records relevant to your practice
This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.
To achieve this, you must:

10.1 complete records at the time or as soon as possible after an event, recording if the notes are written some time after the event

10.2 identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need

10.3 complete records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements

10.4 attribute any entries you make in any paper or electronic records to yourself, making sure they are clearly written, dated and timed, and do not include unnecessary abbreviations, jargon or speculation

13 Recognise and work within the limits of your competence
To achieve this, you must, as appropriate:

…

13.4 take account of your own personal safety as well as the safety of people in your care

18 Advise on, prescribe, supply, dispense or administer medicines within the limits of your training and competence, the law, our guidance and other relevant policies, guidance and regulations
To achieve this, you must:

…

18.2 keep to appropriate guidelines when giving advice on using controlled drugs and recording the prescribing, supply, dispensing or administration of controlled drugs

19 Be aware of, and reduce as far as possible, any potential for harm associated with your practice
To achieve this, you must:

19.1 take measures to reduce as far as possible, the likelihood of mistakes, near misses, harm and the effect of harm if it takes place

…

19.4 take all reasonable personal precautions necessary to avoid any potential health risks to colleagues, people receiving care and the

20 Uphold the reputation of your profession at all times
To achieve this, you must:

20.1 keep to and uphold the standards and values set out in the Code'

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel was of the view that the charges found proved are serious enough to amount to misconduct.

The panel noted that the concerns were not isolated incidents but were multiple incidents over a short period of time, involving vulnerable patients under Ms Diato's care. It noted that the concerns were serious breaches that had the potential to cause harm to patients. The omission to record medication on the MAR chart that was administered to Patient A posed a serious patient safety risk in that a further dose of medication could have been inadvertently administered, which in turn could have had serious consequences for Patient A. The failure to correctly measure doses of medicines to be administered could result in either a suboptimal or excessive dose which could have serious consequences for patients' health.

The panel determined that the concerns identified are basic nursing skills and practice of a registered nurse. It determined that Ms Diato's conduct as per charge 1 and charge 2b and charge 2d, as found proved, are serious failings and departures from the fundamental principles of the Code, with regard to providing safe and effective care to patients.

The panel determined that Ms Diato's failings have the potential to undermine the trust the public places in the nursing profession and would be regarded as '*deplorable'* by fellow practitioners.

The panel concluded that Ms Diato's actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct, Ms Diato's fitness to practise is currently impaired.

In coming to its decision, the panel had regard to the NMC Guidance on *'Impairment'* (Reference: DMA-1 Last Updated: 03/03/2025) in which the following is stated:

> *'The question that will help decide whether a professional's fitness to practise is impaired is:*
>
> *"Can the nurse, midwife or nursing associate practise kindly, safely and professionally?"*
>
> *If the answer to this question is yes, then the likelihood is that the professional's fitness to practise is not impaired.'*

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. To justify that trust, nurses must act with integrity. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

In this regard the panel considered the judgment of Mrs Justice Cox in the case of *CHRE v NMC and Grant* in reaching its decision. In paragraph 74, she said:

> *'In determining whether a practitioner's fitness to practise is impaired by reason of misconduct, the relevant panel should generally consider not only whether the practitioner continues to present a risk to members of the public in his or her current role, but also whether the need to uphold proper professional standards and public confidence in the profession would be undermined if a finding of impairment were not made in the particular circumstances.'*

In paragraph 76, Mrs Justice Cox referred to Dame Janet Smith's "test" which reads as follows:

> *'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or*

determination show that his/her/their fitness to practise is impaired in the sense that S/He/They:

a) *has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*

b) *has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*

c) *has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or*

d) *has in the past acted dishonestly and/or is liable to act dishonestly in the future.'*

The panel concluded that limbs a), b) and c) of the *Grant* test were engaged in this case.

The panel finds that patients were put at unwarranted risk of harm as a result of Ms Diato's misconduct. Ms Diato's misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute.

Regarding insight, the panel had no evidence before it that Ms Diato has shown insight or remorse. The panel was satisfied that the misconduct in this case is capable of being addressed. However, the panel had no evidence before it to suggest that Ms Diato has taken steps to strengthen her practice and no reflection provided to suggest she had taken steps to remediate the concerns and/or what she will do differently in the future.

The panel is of the view that there is a risk of repetition as Ms Diato has not engaged with the process since March 2023. The panel noted that in an email sent to the NMC in March 2023 Ms Diato stated that she was in Ghana, however, it had no information as to what she has been doing since March 2023. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

The panel bore in mind that the overarching objectives of the NMC; to protect, promote and maintain the health, safety, and well-being of the public and patients, and to uphold and protect the wider public interest. This includes promoting and maintaining public confidence in the nursing and midwifery professions and upholding the proper professional standards for members of those professions.

The panel determined that a finding of impairment on public interest grounds is required. It concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case and therefore also finds Ms Diato's fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel was satisfied that Ms Diato's fitness to practise is currently impaired.

Sanction

The panel has considered this case very carefully and has decided to make a suspension order for a period of one year. The effect of this order is that the NMC register will show that Ms Diato's registration has been suspended.

In reaching this decision, the panel has had regard to all the evidence that has been adduced in this case and had careful regard to the Sanctions Guidance (SG) published by the NMC. The panel accepted the advice of the legal assessor.

Representations on sanction

The panel noted that in the Notice of Meeting, dated 15 October 2025, the NMC had advised Ms Diato that it would seek the imposition of a suspension order if it found Ms Diato's fitness to practise currently impaired.

The NMC set out the following aggravating factors:

- Failure in the basic tenets of the profession
- Serious risk of patient harm
- No evidence of insight or remediation

The NMC set out the following mitigating factors:

- No actual patient harm
- No previous fitness to practice (FtP) history

The NMC submitted that taking no further action or imposing a caution order would be wholly disproportionate and would not be sufficient to mitigate the risks identified. It submitted that it would not be adequate to protect the public or satisfy the public interest in this case.

The NMC submitted that a conditions of practice order is not appropriate in this case. It submitted that the concerns are serious and cannot be addressed without Ms Diato's insight into her misconduct. It submitted that there is no evidence of any willingness to positively respond to retraining as Ms Diato has disengaged with her regulator since March 2023 and has stated that she no longer resides in the country. Therefore, any potential conditions that could be formulated are not workable. It further submitted that in the absence of insight, there are no practical conditions that could be put in place to protect the public and maintain public confidence.

The NMC submitted that the appropriate sanction in this case is one of suspension. It submitted that although no actual harm was caused, there was a risk of serious harm to patients. It submitted that there is no evidence of repetition, although it noted that Ms Diato is not in the country. It further submitted that there is no evidence of insight or remediation, and Ms Diato has not engaged with the process, and the NMC did not receive a response to the CE proposed undertakings.

Decision and reasons on sanction

Having found Ms Diato's fitness to practise currently impaired, the panel went on to consider what sanction, if any, it should impose in this case. The panel borne in mind that any sanction imposed must be appropriate and proportionate and, although not intended to be punitive in its effect, may have such consequences. The panel had careful regard to the SG. The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel took into account the following aggravating features:

- Failure in basic tenets of the nursing profession
- No evidence of insight or remediation
- Serious risk of patient harm

The panel also took into account the following mitigating features:

- No actual patient harm

The panel noted that Ms Diato has made partial admissions and has no previous fitness to practise history.

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of the charges found proved. The panel determined that Ms Diato had represented continuing risk to patients and there was a risk of repetition. It noted that Ms Diato had breached the fundamental tenets of the nursing profession and was responsible for failings that undermined the public trust in the profession. The panel decided that it would be wholly disproportionate nor in the public interest to take no further action.

The panel then considered the imposition of a caution order but again determined that, due to the seriousness of the charges found proved, and the public protection issues identified, an order that does not restrict Ms Diato's practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where '*the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that Ms Diato's misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the issues identified. It determined that a caution order would not mitigate the risks identified and would not be sufficient to protect the public. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on Ms Diato's registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable. The panel took into account the SG, in particular:

- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *Identifiable areas of the nurse or midwife's practice in need of assessment and/or retraining;*
- *No evidence of general incompetence;*
- *Patients will not be put in danger either directly or indirectly as a result of the conditions;*
- *The conditions will protect patients during the period they are in force; and*
- *Conditions can be created that can be monitored and assessed.*

The panel is of the view that there are practical and/or workable conditions that could be formulated, given the nature of the charges in this case. The misconduct identified in this case is something that can be addressed through retraining. However, the panel concluded that due to Ms Diato's lack of engagement since March 2023 with her regulator it could not be satisfied that Ms Diato would respond positively to any conditions or supervision that may be put in place. The panel had no evidence of any insight or reflection from Ms Diato into her failings. The panel had no knowledge of what Ms Diato has been doing since March 2023 or where she is, as she stated in an email to the NMC in March 2023 that she was in Ghana at the time.

The panel then went on to consider whether a suspension order would be an appropriate sanction. The SG states that suspension order may be appropriate where some of the following factors are apparent:

- *A single instance of misconduct but where a lesser sanction is not sufficient;*
- *No evidence of harmful deep-seated personality or attitudinal problems; and*

- *In cases where the only issue relates to the nurse or midwife's lack of competence, there is a risk to patient safety if they were allowed to continue to practise even with conditions.*

The panel determined that the charges found proved are serious as there was a risk of serious harm to patients although there was no actual harm caused. It noted that there is no evidence of insight or remediation from Ms Diato into her failings. It determined that there is no evidence of repetition, although it noted that it had no knowledge of Ms Diato's practice or her whereabouts since her last engagement with the NMC in March 2023.

The panel was satisfied that in this case the misconduct was not fundamentally incompatible with remaining on the register.

The panel did go on to consider whether a striking-off order would be proportionate but, taking account of all the information before it, and of the mitigation provided, the panel concluded that it would be disproportionate. The panel noted that there are no deep-seated attitudinal concerns in this case and that the risks identified are remediable. It determined that a suspension order achieves the overarching objective of protecting the public in this case. Whilst the panel acknowledges that a suspension may have a punitive effect, it would be unduly punitive in Ms Diato's case to impose a striking-off order.

Balancing all of these factors the panel has concluded that a suspension order would be the appropriate and proportionate sanction.

The panel noted the hardship such an order may cause Ms Diato. However, this is outweighed by the need to protect the public and the public interest in this case.

The panel considered that this order is necessary to mark the importance of maintaining public confidence in the profession, and to send to the public and the profession a clear message about the standard of behaviour required of a registered nurse.

The panel determined that a suspension order for a period of one year was appropriate in this case to mark the seriousness of the misconduct. The panel noted that Ms Diato can ask for an early review.

At the end of the period of suspension, another panel will review the order. At the review hearing the panel may revoke the order, or it may confirm the order, or it may replace the order with another order.

Any future panel reviewing this case would be assisted by:

- Ms Diato engaging with the regulator and attending a future hearing
- A reflective statement
- Any testimonials or references from employers or colleagues
- Evidence of retraining in Medicines Management
- Ms Diato undertaking a period of supervised practice with regards to correct administration and documentation of medicines
- Reassurance that the eyesight issues raised by Ms Diato during the Meeting Minutes was not at a level that would affect Ms Diato to be able to practice safely and effectively

This will be confirmed to Ms Diato in writing.

Interim order

As the suspension order cannot take effect until the end of the 28-day appeal period, the panel has considered whether an interim order is required in the specific circumstances of this case. It may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest or in Ms Diato's own interests until the suspension sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Representations on interim order

The panel took account of the representations made by the NMC that if the panel makes a finding of impairment on a public protection basis, then an interim order should be in the same terms as the substantive order on the basis that it is necessary for the protection of the public and otherwise in the public interest.

Decision and reasons on interim order

The panel was satisfied that an interim order is necessary for the protection of the public and is otherwise in the public interest. The panel had regard to the seriousness of the facts found proved and the reasons set out in its decision for the substantive order in reaching the decision to impose an interim order.

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's determination for imposing the substantive order. The panel therefore imposed an interim suspension order for a period of 18 months in order to cover the 28-day appeal period and allow for the possibility of an appeal to be made.

If no appeal is made, then the interim suspension order will be replaced by the substantive suspension order 28 days after Ms Diato is sent the decision of this hearing in writing.

That concludes this determination.